

<b>Case Number:</b>	CM15-0069723		
<b>Date Assigned:</b>	04/17/2015	<b>Date of Injury:</b>	03/28/2007
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/13/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: North Carolina, Georgia  
 Certification(s)/Specialty: Family Practice

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 53 year old male, who sustained an industrial injury on 3/28/07. The injured worker was diagnosed as having right shoulder impingement, right glenohumeral laxity and right AC joint arthritis. Treatment to date has included oral medications including opioids and activity restrictions. Currently, the injured worker complains of right shoulder pain 8/10 with medication and 10/10 without medications. Physical exam noted tenderness to palpation in central lumbar spine and right greater trochanter. The treatment plan included continuation of conservative care, request for authorization of r physical therapy and refilling oral medications including Norco, Lunesta, Zanaflex, Prilosec and Intermezzo.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Lunesta 3mg Qty: 180.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Insomnia Treatments.

**Decision rationale:** The CA MTUS is silent on the use of Lunesta. ODG addresses insomnia treatments in the section on pain. ODG states that treatment should be based on the etiology of the insomnia. Pharmacologic agents should be used only after a careful investigation for cause of sleep disturbance. Primary insomnia should be treated with pharmacologic agents while secondary insomnia may be treated with pharmacologic and/or psychological measures. It is important to address all four components of sleep- sleep onset, sleep maintenance, sleep quality and next day function. Lunesta is recognized as the only benzodiazepine based sleep aid, which is FDA, approved for use greater than 35 days. In this case, the medical records do not detail any history of the insomnia or response to treatment with Lunesta. Therefore, there is no documentation of the medical necessity of treatment with Lunesta and the UR denial is upheld.

**Norco 10/325mg Qty: 540.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80-81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 74-89.

**Decision rationale:** CA MTUS allows for the use of opioid medication, such as Norco, for the management of chronic pain and outlines clearly the documentation that would support the need for ongoing use of an opioid. These steps include documenting pain and functional improvement using validated measures at 6 months intervals, documenting the presence or absence of any adverse effects, documenting the efficacy of any other treatments and of any other medications used in pain treatment. The medical record in this case does not use any validated method of recording the response of pain to the opioid medication or of documenting any functional improvement. It does not address the efficacy of concomitant medication therapy. Therefore, the record does not support medical necessity of ongoing opioid therapy with Norco.

**Zanaflex 4mg Qty: 360.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 64-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 63-66.

**Decision rationale:** The CA MTUS allows for the use, with caution, of non-sedating muscle relaxers as second line treatment for acute exacerbations of chronic low back pain. While they may be effective in reducing pain and muscle tension, most studies show no benefits beyond NSAIDs in pain relief. Efficacy diminishes over time and prolonged use may lead to dependency. There is no recommendation for ongoing use in chronic pain. The medical record in

this case does not document an acute exacerbation and the request is for ongoing regular daily use of Zanaflex. This is not medically necessary and the original UR decision is upheld.

**Prilosec 20mg Qty: 360.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 68.

**Decision rationale:** CA MTUS guidelines state that a proton pump inhibitor should be considered for administration with anti-inflammatory medication if there is a high risk for gastrointestinal events. In this case, the medical record does not document any history to indicate a moderate or high risk for gastrointestinal events or of use of anti-inflammatory medication and Prilosec therefore is not medically necessary.

**Intermezzo 1 SL Qty: 180.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation (ODG-TWC) Zolpidem (Ambien).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PAin, Insomnia Treatments.

**Decision rationale:** The CA MTUS is silent on the use of Intermezzo. ODG addresses insomnia treatments in the section on pain. ODG states that treatment should be based on the etiology of the insomnia. Pharmacologic agents should be used only after a careful investigation for cause of sleep disturbance. Primary insomnia should be treated with pharmacologic agents while secondary insomnia may be treated with pharmacologic and/or psychological measures. It is important to address all four components of sleep- sleep onset, sleep maintenance, sleep quality and next day function. Intermezzo is indicated for middle of the night waking when 4 or more hours of sleep time remain. It is approved for periodic use only. Lunesta is recognized as the only benzodiazepine based sleep aid, which is FDA, approved for use greater than 35 days. In this case, the medical records do not detail any history of the insomnia or response to Lunesta is recognized as the only benzodiazepine based sleep aid, which is FDA, approved for use greater than 35 days. In this case, the medical records do not detail any history of the insomnia or response to treatment with Lunesta. Interventions. Therefore, there is no documentation of the medical necessity of treatment with Ambien and the UR denial is upheld.